STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING _____ B. WING _____	R-C 10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00112237 and Investigation of Complaint IN00112802 completed on August 2, 2012. This visit was in conjunction with a PSR to the Recertification and State Licensure Survey completed on August 13, 2012. This visit was in conjunction with a PSR to the Investigation of Complaint IN00115272 completed on September 19, 2012. Complaint: IN00112237-corrected Complaint: IN00112802-corrected Survey dates: October 9 and 10, 2012 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Survey team: Rick Blain, RN - TC Diane Nilson, RN Angela Strass, RN Census bed type: SNF/NF: 129 Total: 129 Census payor type: Medicare: 8 Medicaid: 97 Other: 24 Total: 129	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING _____ B. WING _____	R-C 10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Sample: N/A Kindred Transitional Care and Rehab - Fort Wayne was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Post Survey Revisit (PSR) to the Investigation of Complaint IN00112237 and Investigation of Complaint IN00112802. Quality review completed on October 10, 2012 by Bev Faulkner, RN	{F 000}		